06/002/08/TN 3

POMS

PROGRAM OPERATIONS MANUAL SYSTEM
Part 06
Health Insurance

Chapter 002
General

Subchapter 08
Assignment of Responsibilities

This consolidation incorporates through TN 3.

U.S. Department of Health and Human Services
Social Security Administration
Office of Operational Policy and Procedures
SSA Pub. No. 68-0600208
I.C.N. 994013
March 1989

HE 3.6/5:

READEX FICHE best copy available

Check List of POMS Transmittals Received

TN	Date	Initial	TN	Date	Initial	TN	Date	Initial	TN	Date	Initial
1.			37.			73.			109.		
2.			38.			74.			110.		
3.			39.			75.			111.		
4.			40.			76.			112.		
5.			41.			77.			113.		
6.			42.			78.			114.		
7.			43.			79.			115.		
8.			44.			80.			116.		
9.			45.			81.			117.		
10.			46.			82.			118.		
11.			47.			83.			119.		
12.			48.			84.			120.		
13.			49.			85.			121.		
14.			50.			86.			122.		
15.			51.			87.			123.		
16.			52.			88.			124.		
17.			53.			89.			125.		
18.			54.			90.			126.		
19.			55.			91.			127.		
20.			56.			92.			128.		
21.			57.			93.			129.		
22.			58.			94.			130.		
23.			59.			95.			131.		
24.			60.			96.			132.		
25.			61.			97.			133.		
26.			62.			98.			134.		
27.			63.			99.			135.		
28.			64.			100.			136.		
29.			65.			101.			137.		
30.			66.			102.			138.		
31.			67.			103.			139.		
32.			68.			104.			140.		
33.			69.			105.			141.		
34.			70.			106.			142.		
35.			71.			107.			143.		
36.			72.			108.			144.		

Check List of POMS Transmittals Received

TN	Date	Initial	TN	Date	Initial	TN	Date	Initial	TN	Date	Initial
145.			181.			217.			253.		
146.			182.			218.			254.		
147.			183.			219.			255.		
148.			184.			220.			256.		
149.			185.			221.			257.		
150.			186.			222.			258.		
151.			187.			223.			259.		
152.			188.			224.			260.		
153.			189.			225.			261.		
154.			190.			226.			262.		
155.			191.			227.			263.		
156.			192.			228.			264.		
157.			193.			229.			265.		
158.			194.			230.			266.		
159.			195.			231.			267.		
160.			196.			232.			268.		
161.			197.			233.			269.		
162.			198.			234.			270.		
163.			199.			235.			271.		
164.			200.			236.			272.		
165.			201.			237.			273.		
166.			202.			238.			274.		
167.			203.			239.			275.		
168.			204.			240.			276.		
169.			205.			241.			277.		
170.			206.			242.			278.		
171.			207.			243.			279.		
172.			208.			244.			280.		
173.			209.			245.			281.		
174.			210.			246.			282.		
175.			211.			247.			283.		
176.			212.			248.			284.		
177.			213.			249.			285.		
178.			214.			250.			286.		
179.			215.			251.			287.		
180.			216.			252.			288.		

Chapter HI 002 - General
Subchapter 08 - Assignment of Responsibilities

Claims Manual (CM) Reference	*POMS Reference*
10030	HI 00208.001
10032	HI 00208.005
10038	HI 00208.010
10039	HI 00208.015
10042	HI 00208.020
10043	HI 00208.025
10044	HI 00208.090
10045	HI 00208.070
10046	HI 00208.075
10047	HI 00208.080
10048	HI 00208.030
10050	HI 00208.035
10052	HI 00208.085
10054	HI 00208.095
10064	HI 00208.040
10066	HI 00208.045
10067	HI 00208.055
10068	HI 00208.065
10070	HI 00208.100
10079	HI 00208.060
10081	HI 00208.050 A.
10081 (cont.)	HI 00208.050 B.

00208.000 Assignment of Responsibilities

Section

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GENERAL

00208.000 Assignment of Responsibilities

NOTE: *The Audience for the material in this subchapter is standard throughout and is as follows: OS, OR, SR, EHI, SPEC.*

Administration of the Program

00208.001 General Assignment of Responsibilities

The overall responsibility for the administration of title XVIII rests with the Secretary of HHS. In exercising this responsibility, the Secretary has delegated certain administrative functions to various components of the Dept. In addition, as provided by the Social Security Act, a major role in the administration of title XVIII has been given to public and private organizations.

00208.005 Assignment of Responsibilities within DHHS

The Public Health Service (PHS), the Health Care Financing Administration (HCFA), and the Social Security Administration (SSA), are the HHS agencies involved in administering the Health Insurance program.

00208.010 Role of the HealthCare Financing Administration (HCFA)

HCFA is responsible for policy formulation and various operational aspects of the program. These duties are the responsibility of various components.

A. Health Standards and Quality Bureau (HSQB)

1. Develops, interprets and implements health quality and safety standards and evaluates their impact on the utilization, quality, and cost of health care services;

2. Develops, interprets, implements, and evaluates the conditions and standards of participation by and monitors and validates certification activities for providers and suppliers of health services under the Medicare and Medicaid programs;

3. Develops, interprets, implements, and evaluates policies for professional standards review, related peer review, utilization review, and utilization control programs under Medicare and Medicaid;

4. Develops and manages grants with PSRO's and contacts with statewide Professional Standards Review Councils and develops policies regarding operational aspects of peer and utilization review programs, including their monitoring and evaluation;

5. Develops and evaluates health care and health-related policies related to implementation of the END Stage Renal Disease (ESRD) provision and coordinates with Medicare the implementation and monitoring of their policies;

6. Determines information and data reporting, collection and systems requirements for the PSRO and provider certification programs;

7. Serves as the HCFA focal point in the agency's interface with the Assistant Secretary for Health and the Public Health Service on Medical Care Standards Quality Assurance, and other health-related matters.

B. Health Care Financing Administration

The Health Care Financing Administration has the primary responsibility for the Health Insurance program. However, nearly every major bureau or office of SSA is involved in some way in carrying out HCFA responsibilities.

This responsibility involves the development of policies, guidelines, and procedures used by the intermediaries, carriers, and components of HCFA in carrying out their responsibilities for administering the Health Insurance provisions of the Social Security Act.

C. Medicaid Bureau

The medicaid Bureau has the primary responsibility for administering title XIX of the Social Security Act. As such, it develops and promulgates appropriate policies.

D. Bureau of Quality Control (BQC)

The Bureau of Quality Control has responsibility for insuring the integrity of the Medicare program and investigating all complaints of fraud or abuse against the program. In the furtherance of these objectives, BQC has occasion to work closely with carriers and intermediaries, the HCFA regional and central office components, and DO's among other units.

NOTE: *By law and regulation, the Inspector General's office of Investigations, (OI), has the responsibility to supervise, coordinate and provide direction for Medicare fraud cases.*

00208.015 Role of the Social Security Administration (SSA)

SSA has responsibility for general management and operational aspects of the Medicare Program. This includes:

A. Determinations of an individual's entitlement to benefits; hearings and appeals resulting from these determinations, and the maintenance of eligibility and utilization records;

B. Through the network of district, branch and teleservice centers, providing the locations where the public can readily acquire program information.

00208.020 Responsibilities of the Health Care Financing Administration Regional Offices

The Health Care Financing Administration RO is responsible for a wide range of administrative activities. These include administrative coordination and operational appraisals as well as program interpretation and evaluation. Accordingly, the RO role in coordination of operational activities and assessment of program effectiveness involves direct contact with intermediaries and carriers. The RO also works closely with all other agencies and organizations which have direct or indirect involvement in the Medicare program.

The RO is empowered to exercise the necessary authority, not prohibited by other specific delegations, for effective implementation of the Medicare program in its geographic area. It has the responsibility, for example, to emphasize and reiterate program instructions emanating from central office when it believes that circumstances so warrant. It also makes current appraisals of specific program or operational issues. This may require compilation and reporting of selective data within designated time periods. While various HCFA components are involved in the administration of the Medicare program, the HCFA RO is the focal point for control and liaison between intermediary, carrier, and SSA activities in the field. This role also applies to policy interpretation and the referral to central office of issues which may require the establishment or revision of policy. Through these appraisals and recommendations, the RO directly participates in the development of policy at the central office level.

00208.025 Role of the HSQ RO in Certification

The RO's handle all matters relating to the survey and certification program at the regional level. Their principal activities are:

A. Review certification recommendations made by State agencies for Medicare purposes and issue provider agreements to those which meet the requirement. In making a decision of substantial compliance and eligibility to participate, the HSQ RO relies on the evidence submitted by the provider or supplier, the State agency, the Office of Civil Rights, the Bureau of Quality Control and the PSRO's.

B. Terminate those providers and suppliers that, on resurvey, are found not to be in substantial compliance.

00208.030 Role of the Division of Claims Processing, Bureau of Support Services

The responsibilities of the Division of Claims Processing, Office of Direct Reimbursement (ODR) are basically the same as those of intermediaries and carriers as outlined in HI 00208.090.

The Claims operation Branch (COB), is that part of ODR which processes claims for those hospitals, SNF's, and HHA's which have elected to deal directly with HCFA and process claims for provider-based physician services in governmental facilities.

Because COB is located so far from most of the providers it serves, certain functions usually handled by an intermediary (e.g., the transmission of admission and start of care data to OCRO) are handled by or with the assistance of DO's (see ~~CM-10590 FF~~.).
SM 00706.135

00208.035 Role of the Division of Reimbursement, Recovery, and Reconsideration Evaluation, Bureau of Program Operations

The Division of Reimbursement, Recovery, and Reconsideration Evaluation is primarily responsible for directing the processing of HCFA appeals and overpayments, and planning, directing and coordinating the monitoring of Medicare and Medicaid Program guidelines designed to review and evaluate HCFA reimbursement and accounting policy. Some of the Division's specific functions are as follows:

A. The adjudication of requests for reconsideration of Part A claim denials initially processed by intermediaries, which are unable to conduct their own reconsiderations.

B. The evaluation of intermediaries performance in processing Part A appeals and the preparation of reports from which intermediaries are rated for contractor Performance Evaluation Program purposes.

C. The review of all Medicare, Medicaid, and PSRO decisions on which a hearing before the Office of Hearings and Appeals has been requested.

D. The final review of all Part A Medicare and Medicaid decisions by OHA on health insurance appeals.

E. The evaluation and review of Medicare beneficiary, provider, and physician/supplier overpayment cases, and the determination and adjudication of recovery actions.

00208.040 District Office Contacts with Providers of Services

A. General

DO's have a special responsibility in the area of health services because of their unique insights into the problems, failures, and successes of programs and instructions within their service areas. In order to fulfill this responsibility, DO's have been selected as community focal points. They are responsible for: (1) establishing a routine visit and report program involving only Medicare providers of services; (2) reviewing and transmitting public complaints about any medical facility. In addition, DO's refer information about obvious substandard conditions observed by a DO representative while conducting regular Social Security business at a facility, whether it is certified for title XVIII or not (see HI 00208.045). If the report concerns substandard or safety conditions in a certified provider or supplier, submit the original to the HSQ RO and a copy to AC Field

B. DO Role Before HCFA Signs the Agreement

DO's may receive inquiries about the certification process. These questions may deal with general or specific conditions of participation, utilization review, transfer agreements, physician certification and recertification, etc. These are technical matters about which the DO may have only general knowledge. Generally, DO's should refer the inquiry or the inquirer to either the State agency or to the HCFA RO.

C. DO Role After HCFA Signs the Agreement

1. INITIAL CONTACT

As soon as possible after learning that a provider has been certified, the district manager or the assistant district manager should make a personal contact with the provider. This contact is important in fostering effective cooperation among all of the participants in the Health Insurance program.

Discussion should cover such items as the role and services of the DO, with specific mention of assistance available with health insurance claim number problems. Another subject, particularly with hospitals, is the application procedure discussed in section 308 of the Hospital Manual (see ~~CM 2020 ff.~~). Discussions with direct dealing facilities should, of course, establish local arrangements for DO receipt of hospital admission notices.

GN00204.005

If the hospital's administrator raises questions or comments about billing procedures, reimbursement, or related problems, refer him to the intermediary. Report promptly to the HCFA RO any significant questions or problems encountered. (This could include significant questions or comments which the provider intends to direct to the intermediary.)

2. CONTINUING CONTACTS

Participating provider contacts should be based on request or need, e.g., problems are identified by the news media or there is a beneficiary complaint. Persons making these visits should be experienced and knowledgeable about the program and fully aware of the sensitive relationships involved. They should take a low-key approach, and avoid giving the impression that they are "investigators." This point cannot be overemphasized. At the conclusion of the visit, a report should be prepared and the original submitted to the HCFA Bureau and a copy to the AC Field.

00208.045 Complaints Against Providers

A. General

Medical facilities are required to meet certain established standards in order to participate under Medicare. State agencies are responsible for conducting the certification and recertification surveys to determine initial and continuing compliance with the conditions of participation (see HI 00208.075). For nonparticipating providers, various licensing and other regulatory requirements are enforced by the individual States.

B. DO Responsibility

DO's are neither equipped nor assigned the responsibility to deal with the certification or licensing process; however, in the course of their regular business they visit medical facilities which may or may not be certified under title XVIII.

All DO employees should be alert to and report to the HSQ RO obvious substandard conditions in all medical facilities (participating and nonparticipating providers), whether brought to their attention by personal observation or through complaints by the public.

Reports of substandard conditions in facilities participating under Medicare should be made promptly, sending a Health Facility Complaint Memorandum (see C. below, and HI 00208.050) to the HSQ RO, with a copy to AC Field when there are apparent difficulties in the facility. The HSQ regional staff will either investigate or refer the complaint to the appropriate State agency responsible for certification and licensing. The HSQ RO will periodically report back to DO's on the positive results of their referrals.

Matters relating to billing, reimbursement, etc. should be reported to the HCFA RO.

C. Preparation of the Health Facility Complaint Memorandum

Prepare the form in quadruplicate (as well as any attachments), to report complaints of substandard conditions. The appropriate conditions are prescribed in regulations dealing with the various types of providers, and are available to the DO. The information contained on the memorandum must be as specific as possible. This will ensure a more productive investigation.

Complaints concerning the treatment received by an individual patient can best be resolved if specific information is available, e.g., name, claim number, date of occurrence, names of those involved, and actions taken by the complainant to resolve the issue. Indicate if the complaint has brought the situation to the attention of the facility or any other government agency.

In all instances be sure to attach whatever material is available to document the complaint. This includes bills, receipts, or notices of any kind (including utilization review notices). Send three copies of the memorandum (and attachments) to the Health Standards and Quality Bureau. Send one copy to the AC Field. DO retention of material will be determined by regional and local guidelines.

Except when regional instructions indicate otherwise, before a complaint is referred to the HSQ RO, it should be reviewed by someone designated by management to screen out complaints which do not require a referral for investigation.

Complaints which need not be referred include events which occurred more than one year ago; complaints from the same person which duplicate previously submitted complaints; situations involving only an explanation of some routine aspect of the Medicare law; appeals which should be properly disposed of through the appeals process (see ~~10800 ff.~~); and those situations which generally do not affect either the health or safety of the patient.

If, after considering the above and exercising judgement as to whether the circumstances represent a bona fide complaint, the DO is undecided, but feels that there may be reason to doubt the validity of the complaint, forward it to the HSQ RO with an RC explaining the basis for the DO doubts. The RC will assist the RO in deciding whether to forward the complaint for investigation. If the complaint is forwarded, the DO assessment will help decide the timing of the investigation.

00208.050 Health Facility Complaint Memorandum

A. Exhibit

TO :

FROM : DISTRICT OFFICE_____

SUBJECT: HEALTH FACILITY COMPLAINT DATE

Health Facility (name and address) RO USE ONLY

_____ title XVIII ____

_____ title XIX ____

_____ title VI ____

other ____

Nature of Complaint (be specific and use reverse if more space needed)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

If this is not a general complaint against the facility, but involves some other type of complaint, e.g., billing, indicate the patient's name and Medicare claim number_____

_____

Name of Complainant (Relationship to patient) Address Telephone (Day)

Does complainant wish to remain anonymous?_____If "yes" give the reason(s).

_____

(For local reproduction and usage)

B. Completion and Routing of Complaint Form

Complete the form after inserting the "TO" information.

Route the memorandum to the Health Standards and Quality Bureau RO all complaints relating to substandard conditions in participating providers and suppliers.

Route the memorandum to the HCFA RO all complaints dealing with billing and reimbursement.

00208.055 DO Role in the Public Disclosure of Survey Information

Members of the public have the right to inspect information obtained from surveys of Medicare and Medicaid providers and supplier. This includes completed survey forms, statements of deficiencies, plans of correction, comments submitted by the institutions, and State agency revisit report. Survey data is made available for inspection only after it has been reviewed and approved by the HSQ RO.

Each DO, excluding metropolitan branch offices, is required to establish and maintain a file containing the current HCFA-2567, Statement of Deficiencies and Plan of Correction, on all providers and suppliers in their service area. The HSQ RO and the Medicaid State agency forward the HCFA-2567 to the servicing DO, and an identical copy to the local public assistance offices. When a subsequent HCFA-2567 is received from the RO, discard any earlier material concerning the provider's deficiencies and file the new HCFA-2567 in place of the old material.

The DO can assume it is authorized to release to the public any material received from the HSQ RO or the medicaid State agency relating to provider deficiencies. Interested members of the public may inspect the HCFA-2567 at either the DO or the public assistance office. (See ~~CM-7301.5~~ GNO3301 for fees to be paid for copies.) Should survey data other than the HCFA-2567 be requested, request it from the HSQ RO (or the Medicaid State agency, if this is more practical). The HSQ RO will probably reply directly to the inquirer that the information is available for inspection.

DO's may receive inquiries about facilities located in another DO's service area. Offer to telephone the servicing DO for copies of its file. Do not refer the requester to the other DO unless he prefers to get the information himself.

00208.060 DO Handling—Complaints of Discrimination

Although public or beneficiary complaints of provider discrimination may be filed directly with OCR, they may also be filed with the DO. Complaints of provider discrimination on the basis of race, color, or national origin received in the DO should be routed to the RO of OCR at the address indicated in C. below. Under no circumstances should complaints not related to discrimination under title VI be forwarded to OCR. If more than one type of complaint against the same provider involved, only the one relating to provider discrimination on the basis of race, color, or national origin should be forwarded to OCR.

A. Confidentiality of Identity of Individual Filing Complaint

HCFA and SSA should protect the identity of individuals filing complaints of discrimination and of instructions against which charges are made. Should an individual be reluctant to reveal his identity, accept an annonymous complaint. DO's should keep in mind that disclosure of identity of a person filing a charge of discrimination could result in his economic or even personal harm. Similarly, the reputation of a provider could be unjustly impaired by disclosure that a complaint had been filed against it.

B. Information to be Obtained about Complaint

The following basic information should be obtained and recorded on an SSA-5002, Report of Contact:

1. The name and address of the facility where the incident occurred;
2. The date the incident occurred;
3. The basis for the complaint (race, color, or national origin);
4. The services or facilities about which the complaint is being made (admissions, bed assignment, dual standards for the cost of medical service, dual standards in assignments to or use of hospital facilities, visiting privileges, etc.) including a complete narrative description concerning the nature of the practices alleged to be discriminatory. When possible, names and titles of persons involved should be given.
5. The name, address, and telephone number, if any, of the complainant. This information may be needed to contact the person for more information and to notify the person of the results of the investigation. If the complainant appears to be reluctant to identify himself explain that the information will be kept confidential and will not be released to anyone without his consent. If he refuses to give this information, accept the complaint and indicate that the complainant prefers to remain anonymous.
6. If a complaint has been made to the provider or the State health or welfare department, indicate to whom the complaint was made, the date, and the outcome if known.

C. Routing of Complaint

A single copy of the complaint should be routed directly to the Regional Director for OCR, DHHS, who has jurisdiction for the region in which the provider is located.

The envelope should bear the legend "Confidential-Administrative Mail." and be addressed to the "Regional OCR Director, Department of Health and Human Services," at the addresses shown below:

DHHS Region I	-	John Fitzgerald Kennedy Federal Building Boston, MA 02203
DHHS Region II	-	26 Federal Plaza New York, NY 10007
DHHS Region III	-	PO Box 12840 Philadelphia, PA, 19108
DHHS Region IV	-	50 Seventh St NE Atlanta, GA 30323
DHHS Region V	-	200 S Wacker Dr Chicago, IL 60606
DHHS Region VI	-	1114 Commerce St Dallas, TX 75202
DHHS Region VII	-	601 East 12 St Kansas City, MO 64106
DHHS Region VIII	-	721 19 St. Denver, CO 80202
DHHS Region IX	-	50 Fulton St. San Francisco, CA 94102
DHHS Region X	-	Arcade Plaza Bldg. Seattle, WA 98101

D. Instructions for Individuals Who Wish to Follow Up a Complaint

When an individual files a complaint, he should be informed that it will be forwarded to OCR which will acknowledge receipt and after investigation, notify him of the outcome. The processing time of such complaints varies, so advise the individual that further contacts regarding the matter should be made with OCR at the address shown in C. above.

00208.065 Terminations

A. Arranging for Public Notice of Involuntary Termination

When a provider is involuntarily terminated, the HSQ RO contacts the servicing DO to arrange for the publication of a notice in the local newspaper(s) announcing the termination and the reasons for it. (A newspaper notice is optional for independent laboratories and certain other suppliers of services.)

It is the DO's responsibility to contact the local newspaper(s) and arrange for publication of the notice. The DO receives from the HSQ RO the text of the public notice and an original and one copy of SF-1143, Advertising Order, which should be given to the publisher. Since many aged people have poor vision, the notice should be in print larger than standard newsprint. The advertisement should be one or two columns totalling not less than 1 1/2 column inches (1 column × 3 1/2 inches, or 2 columns × 1 3/4 inches) and not more than 8 column inches.

Inform the publisher that one of the following options may be used to claim reimbursement:

1. The back of the original SF-1143 may be completed with either a copy of the advertisement attached or a certification made in the space provided on the form; or
2. Any billing form may be substituted with a copy of the advertisement or a certification attached to the original SF-1143.

Instruct the publisher to mail the original of the SF-1143 and attachments to the HSQ RO at the address given near the bottom of the form. The publisher may retain the copy for his files. Questions relating to the public notice should be referred to the HSQ RO.

B. Effects of an Involuntary Termination on Patients

For hospitals and skilled nursing home patients, the Health Insurance program will not make payment for services furnished on or after the effective date of termination. For patients admitted prior to the date of termination, payment may continue to be made for up to 30 days for services furnished on or after the date of termination. The provider being terminated is required to submit a list to the intermediary showing the names and health insurance claim numbers for patients admitted prior to the date of termination and who are still patients on the date of termination. If hospital and skilled nursing home services are needed beyond the 30 day period, the patient must be transferred to an approved provider in order for Medicare/Medicaid payments to continue beyond the 30 days.

For home health agencies, the Health Insurance program will not make payment for services furnished patients whose plan of treatment was established on or after the date of termination. For patients whose plan of treatment was established before the date of termination, payment will be made until the end of the plan of treatment or to the end of the calendar year, whichever is earlier.

For a supplier of services (an independent laboratory, portable x-ray, out-patient physical therapy, or speech pathology), the effective date of termination is the first day of the first month which is at least 15 days after the date the notice of termination is mailed. No payment will be made for services rendered on or after the effective date of the termination.

C. Appeal Rights of Terminated Providers/Suppliers

A provider or supplier which does not believe the termination decision is correct has the right to request a hearing before an administrative law judge. The request for a hearing should be filed with the RO within 60 days of the date of receipt of the decision of termination. Should any request for reconsideration, hearing, appeal, or review of a termination be filed in the DO, forward it to the HSQ RO.

00208.070 Participation of Health Maintenance Organizations (HMO's) and Competitive Medical Plans (CMPs)

A. General

Section 1876 of the Social Security Act permits a Medicare beneficiary eligible for Part A and Part B, or Part B only, to choose to have covered items and services furnished through a Health Maintenance Or-

ganization (HMO) or Competitive Medical Plan (CMP), by enrolling in a qualified organization which has entered into a contract with the Secretary to participate as an HMO/CMP under Medicare. For purposes of discussion, HMOs and CMPs will be referred to hereinafter as HMOs.

An HMO is for Medicare purposes, a public or private organization which provides (either directly or through arrangements with others) comprehensive health services to enrolled members who live within a specified geographic area. The beneficiaries pay a predetermined premium which covers the medical expenses without regard to the frequency or extent of covered services furnished. An HMO geographic area is the area in which it offers the full range of its services to its members.

B. Types of HMOs

1. STAFF MODEL (CLOSED PANEL)

At the least, primary care services are provided directly through a salaried staff in one or more clinic settings. These physicians are paid employees of the organization. This model provides its members with comprehensive services which are delivered at single or multiple sites.

2. GROUP PRACTICE OR MEDICAL GROUP MODEL (CLOSED PANEL)

The second model is usually referred to as a Medical Group. Within this model, the HMO acts as the fiscal agent which arranges for health services through physician group contracts. These contracts are with a legally-organized medical group, e.g., a partnership or corporation composed of licensed physicians as well as other health professionals. In the multi-specialty group practice arrangement, all physicians are often located in one facility and are usually compensated by the physician group on a salary or capitation basis. It is possible for a portion of each physician's HMO income to be withheld and pooled as an incentive to control unnecessary utilization. The primary difference between the Staff and Group model HMOs is that staff HMOs provide primary care services directly through their own salaried staff, while the Group model HMOs "contract-out" for these services.

3. FOUNDATION OR INDIVIDUAL PRACTICE ASSOCIATION (IPA) MODEL (OPEN PANEL)

Normally, the third HMO model either directly enters into contracts with physicians who practice in their individual offices or the HMO contracts with an organization (IPA) which represents the physicians that practice in their own offices. These doctors provide services to organization members under previously agreed upon fee schedules or other arrangements. The IPA organization provides services at a variety of locations, including doctor's own office, permitting the organization's enrollees to retain the mode of delivery to which he or she may be accustomed.

4. NETWORK MODEL:

The fourth type HMO is a hybrid between the IPA model and group practice model. Services are provided through a series of contractual relationships between the organization and its various physician components.

C. Types of Medicare Contracts

There are two types of Medicare/HMO contracts. One is called a risk contract and the other is called a cost contract. Understanding the difference between the two is important to Medicare beneficiaries primarily because the risk type contract has a *"lock-in"* feature. Except for emergency care anywhere and urgently-needed care while temporarily outside the HMO's geographic area, this means that all enrollees are locked into receiving all services from the HMO. Another exception to this rule applies to those HMO enrollees that permanently reside outside the organization's geographic area. These enrollees are not locked into the HMO. Consequently, unless one of the above exceptions applies, neither the HMO nor Medicare will pay for the health care.

1. COST CONTRACTS

The rules for cost contracts are, for the most part, the same as rules which have been in effect since 1973. For contract periods beginning January 1, 1986, or later, organizations are paid for the reasonable cost of services furnished to Medicare members, up to Medicare's adjusted average per capita cost (AAPCC). For contract periods beginning before January 1, 1986, the organizations are paid for the reasonable cost of services even if it exceeds the AAPCC. The AAPCC is 100 percent of what the average Medicare cost would be for a Medicare member if that member had not joined the HMO.

Medicare enrollees pay the organization a monthly premium for Medicare deductibles and coinsurance which apply to services they receive through the organization. A Medicare enrollee is not restricted to using the organization for his or her medical services. The member may receive services out of the plan and Medicare will pay for them as if the person were not an enrollee of the organization. Of course, unless the enrollee's contract with the plan provides otherwise, the Medicare enrollee must pay any deductible, coinsurance or unreasonable charges which applies to these out-of-plan services.

2. RISK CONTRACTS

For organizations with a TEFRA contract, HCFA makes payment on a prepaid capitation basis *without* retroactive adjustment of the payment rate to organizations. TEFRA is an acronym for the Tax Equity and Fiscal Responsibility Act of 1982 which altered the way we deal with risk organizations. Specifically, TEFRA makes it easier for organizations to contract with HCFA and for HCFA to prospectively pay HMOs on a capitated risk basis. Medicare pays a TEFRA risk HMO a fixed monthly amount equal to 95 percent of the AAPCC for the HMO's geographic area.

As stated above, except for emergency care, urgently needed care, or for enrollees who permanently reside outside the HMO's geographic area, when a Medicare beneficiary enrolls in an HMO with a risk contract, the beneficiary agrees to receive all health care services through the HMO. Consequently, if the beneficiary receives Medicare services outside the HMO, neither Medicare nor the HMO will pay for these services. In other words, unless one of the exceptions apply, the beneficiary is *"locked-in" to*

receiving care from the HMO. We have emphasized the "lock-in" provision because it is very important that the beneficiary fully understands it and the negative financial impact it will have should he or she violate this provision.

D. Enrolling In an HMO

HMOs may offer continuous open enrollment or one or more open enrollment periods per year. Each HMO must, at a minimum, have at least one open enrollment period annually of 30 consecutive days. Information about enrollment periods should be obtained from the HMOs.

Unless the following exceptions exist, HMOs cannot deny entry on the basis of the beneficiary's health/condition. Beneficiaries with End Stage Renal Disease (ESRD) are excluded from enrollment in HMOs. However, a beneficiary that develops ESRD, after enrolling in an HMO, may not be disenrolled. Accordingly, health screening is not permitted except on questions relative to ESRD. Also, beneficiaries who have elected hospice care are not eligible to enroll in an HMO as long as the hospice election remains in effect.

To enroll in a risk or cost HMO, the beneficiary must meet the following requirements:

Have Medicare Part B coverage;

Pay any HCFA-approved premium charged by the HMO (this premium is in addition to the Part B insurance premium which still must be paid by the beneficiary to Medicare); and

Cannot belong to any other HMO.

After a beneficiary applies at the HMO for enrollment, the HMO submits the applicant's name and HIC number to HCFA in Baltimore for Medicare entitlement verification. The HMO sends a list of applicants to HCFA once a month. HCFA will respond to the HMO by either accepting the enrollment or, if entitlement requirements or clerical accuracy are not met, rejecting the enrollment. If the enrollment is accepted, HCFA will annotate the beneficiary's HI record showing HMO enrollment. Conversely, the reason(s) for rejection of an application are also annotated.

E. Benefits Offered by Contracting Organizations

HMOs with Medicare contracts must offer at least all services covered byMedicare that are generally available in their area. They may also offer services or benefits above and beyond Medicare covered services. Depending upon the contractual arrangements, some of the services may be offered free of additional charge (over and above the premium which covers normal Medicare deductible and coinsurance amounts). Some services may be offered for an additional charge as a "high option package." Also, HMOs may choose to reduce or eliminate the deductible and coinsurance premium.

A fixed monthly payment makes budgeting by the beneficiary for health care expenses easier. Although HMOs may charge nominal co-payment fees for individual services, normally HMOs do not have any charges for in-plan covered services. Virtually all of the risk type HMOs offer additional services beyond what Medicare covers at no charge to the enrollee.

With emphasis toward treating illnesses early, helping the enrollees stay healthy, and controlling overutilization of health care services, the HMO saves money which results in lower costs to the enrollee. In addition, emergency care is available any time and the enrollee does not have paperwork/claim forms to fill out.

F. Government Monitoring — Initial and Ongoing

Prior to contracting with HCFA, an HMO must go through an extensive application and review process by the United States Public Health Service (USPHS). In order to qualify as an HMO, an organization must show that it meets specific operational requirements, is fiscally sound, has a system for assurance of quality care, and will offer a wide range of services which are accessible to enrollees. Subsequently, an HMO must apply to HCFA and show that it also meets special Medicare requirements under the Social Security Act and published regulations.

After becoming qualified by the USPHS, HMOs continue to be monitored by that organization. After contracting with HCFA, HMOs are continually monitored by the HCFA Regional Offices to ensure that all Medicare contractual requirements are met.

G. Medicare Beneficiaries Do Not Lose Medicare

A Medicare beneficiary that joins an HMO does not give up his or her Medicare coverage. The covered services of Medicare are merely being paid for under a different payment system. The Medicare beneficiary keeps his or her Medicare card and remains on the Government's Medicare rolls as long as the usual requirements for entitlement are met.

H. Disenrollment

A Medicare enrollee may disenroll from an HMO at any time by giving the organization a signed, dated, written request in the form required by the organization in the month prior to the month in which the enrollee wishes to terminate enrollment. Disenrollment and reinstatement to the traditional fee-for-service Medicare program will be effective, if the enrollee so desires, on the first of the month following the month in which the disenrollment was requested. The organization must submit a disenrollment notice to HCFA promptly following the enrollee's request and furnish the enrollee with a copy of the disenrollment notice. A risk contracting organization must also provide the enrollee with a written notice advising the enrollee that during that period of time prior to the effective date of disenrollment, the enrollee must continue to receive Medicare benefits (with the exception of emergency services anywhere and urgently needed services while temporarily outside of the HMOs service area) from the HMO.

However, if a Medicare enrollee contacts the Social Security FO wishing to disenroll, see HI 00208.071.

I. Appeal Rights

The Medicare enrollee retains regular Medicare appeal rights in the event of dissatisfaction with a determination of the plan regarding liability for service

furnished or the plan's refusal to provide or arrange for a Medicare covered service. Regardless of the amount in controversy, the enrollee can receive a Medicare reconsideration determination. The reconsideration is by HCFA, with input from the HMO, if it initially adjudicated the claim, or by the intermediary or carrier if they adjudicated the claim. Also, the beneficiary is entitled to a hearing if the amount in controversy is $100 or more, and a judicial review if the amount of the controversy is $1,000 or more. As for any other Medicare beneficiary, the Medicare appeal process of an HMO enrollee may be initiated in the SSA offices.

J. Health Insurance Master Record Queries (HMO, ESQ, or USQ)

Once enrolled in the HMO, the beneficiary's HI record will contain one of the following codes in the JUR field: A, B, C, 1, or 2. The alpha codes mean that the beneficiary is enrolled in an HMO with a lock-in contract (Risk HMO). The numeric codes indicate enrollment in an HMO without a lock-in contract (Cost HMO).

HMO problem cases involving the HI master record cannot be resolved using the normal HCFA-2178 problem referral procedure. These cases should be referred to the HCFA regional office that services the HMO.

K. FO Handling of Inquiries/Problems

Most of the inquiries received by SSA field offices can be handled by referring the inquirer to the specific HMO(s) in the area. A list of HMOs will be sent to your office by HCFA central office under separate cover. This list will be updated periodically.

The pamphlet "Medicare and Prepayment Plans" (HCFA publication number 02143, Inventory Control Number 488339) is a good reference for people unfamiliar with the concept of HMOs. Field offices may wish to order additional copies through the SSA Supply System. Limited copies are also available from the HCFA RO.

Problems that occur in the enrollment/disenrollment process are usually resolved between the HMO and HCFA in Baltimore. These problems should only be referred to the HCFA RO after attempts to resolve them have been made by the enrollee through the HMO. Refer problem cases to the HCFA RO via a memorandum. Include copies of reports of contact and a HI query, if applicable.

00208.071 Disenrollment From HMOs/CMPs Through Social Security Field Offices

A. General

The Sixth Omnibus Budget Reconciliation Act passed in 1986 allows Medicare beneficiaries enrolled in prepaid health plans, also referred to as health maintenance organizations (HMOs) and competitive medical plans (CMPs), to disenroll from those plans at Social Security field offices (FOs) effective June 1, 1987. This provision was passed to allow Medicare beneficiaries the opportunity to go to a "neutral" third party to disenroll from prepaid health plans. This is only an option for beneficiaries. Beneficiaries may still disenroll directly from the prepaid plans (see HI 00208.070 H.).

B. Field Office Action

Effective June 1, 1987, when a beneficiary, wishing to disenroll from an HMO/CMP, contacts your FO, complete, on the beneficiary's behalf, the HMO disenrollment form HCFA-566 (1-88) and have the form signed by the beneficiary. The earliest effective date of the disenrollment is the first day of the month following the disenrollment application. Disenrollments are only effective on the first day of each month. For example, a beneficiary completing a disenrollment application on June 23, 1987, is disenrolled from the HMO on July 1, 1987. If the beneficiary does not reenroll in another HMO, he/she is automatically entitled to Medicare benefits through the regular Medicare fee-for-service program effective July 1st. If the beneficiary has already enrolled in another HMO, do not complete the disenrollment form for the previous HMO (See Section L below, Automatic Transfers).

Disenrollments can be made prospectively for up to 3 months. For example, a disenrollment application completed on August 3, 1987, can be effective either September 1, October 1, or November 1. However, the disenrollment cannot be made effective later than November 1. Since most beneficiaries prefer the earliest possible disenrollment date (i.e., the first day of the following month), do not explain the 3-month disenrollment option unless the beneficiary inquires about alternative disenrollment dates.

C. Eligibility Status Query

Obtain an eligibility status query (ESQ) prior to inputting the disenrollment request. The query identifies HMO enrollment. In some cases, the beneficiary may have already been disenrolled by the plan, or may have joined another HMO, and therefore, automatically disenrolled from the previous plan. An ESQ request eliminates unnecessary duplication.

If the ESQ shows no HMO enrollment, the disenrollment request is sent to the servicing regional office along with the ESQ. *Do not key the disenrollment data into the system.*

D. Completion of Form/Input of Data

The form HCFA-566 (1-88) is completed by a service representative or a higher-graded field office employee.

1. BN - BENEFICIARY NAME

This is a mandatory field. Enter up to the first 12 letters of the beneficiary's last name, up to 5 letters of the first name and the middle initial. A comma must be inserted between the last and first name only.

2. CN - CLAIM NUMBER

This is a mandatory field. Enter the beneficiary's HI claim number.

3. SEX

This is a mandatory field. Enter M or F.

4. ED - EFFECTIVE DATE

This is a mandatory field. Enter the six-position month, day and year (e.g., 090187). The day date must always be 01.

5. TRANSACTION CODE

This is a preprinted transaction code number 53 in which no action is necessary. It designates the disenrollment request was processed through an SSA district office.

6. UN - UNIT

This is a mandatory field. Enter field office unit designation up to six positions. Depending on your type of equipment, use the following instructions to call up the HMOD mask and input the data from the completed form:

SSADARS/PARADYNE Terminal:

a. Depress SOM key (start of message)
b. Key the mask ID HMOD
c. Depress the TRANSMIT key
d. Input data on mask as it appears on disenrollment form
e. Verify the data to insure its accuracy before transmitting
f. Depress the TRANSMIT key
g. If the data is correct, a message receipt appears on the 12th line of the screen.

SSADARS/DCU Terminal:

a. Key in mask ID HMOD
b. Depress the ENTER key
c. Input data on the mask as it appears on the disenrollment form
d. Verify the input data to insure its accuracy
e. Depress the ENTER key
f. If the data is correct, a message receipt appears on the 24th line of the screen.

Transmit the data on a daily basis in order to update the beneficiaries' record as soon as possible.

E. Telephone Requests

Beneficiaries may request HMO disenrollment by telephoning the FO. Complete the form HCFA-566(1-88) over the telephone and mail it to the beneficiary for signature. Instruct the beneficiary to verify the information, sign the form, and return all 4 copies of the form to the FO. The effective date of the disenrollment is the first day of the following month after receipt by the FO of the signed and dated disenrollment form. Upon receipt, the FO makes input as in Section D and mails the RO and HMO copies to the HCFA RO (Attn: HMO Section) in accordance with procedures in H.1. The FO also mails the beneficiary copy back to the beneficiary.

For telephone requests received in the latter part of the month, i.e., in the last 8 days, inform the beneficiary of the importance of returning the signed disenrollment form to the FO before the end of the month to assure disenrollment the first day of the following month.

F. Mail Requests

Beneficiaries may request HMO disenrollment by letter mailed to the FO. If the intent of the letter is clear (i.e., a disenrollment is requested) and the exact disenrollment date can be determined by the FO representative, complete the HCFA-566. On the beneficiary signature line, enter "PER THE ATTACHED LETTER." The FO makes input as in Section D and attaches a copy of the beneficiary letter to all copies of Form HCFA-566. The FO mails the RO and HMO copies (with the incoming letter attached to each copy) to the HCFA RO (Attn: HMO Section) in accordance with procedures in J.1. The FO also mails the beneficiary copy (with incoming letter attached) back to the beneficiary.

G. Retention of Forms

Retain the original completed form for 90 days following input into the system. Give the beneficiary copy of the form to the beneficiary for his/her records. Send the RO and HMO copies of the form to the HCFA RO (see Section J.1.). (No copy of the form is maintained by HCFA central office.)

H. Enrollment

A beneficiary cannot enroll in an HMO/CMP through the FO. Enrollment must occur directly with the plan itself.

I. Notification to the HMO/CMP

Since HMOs are paid on a prospective basis for each Medicare beneficiary enrolled in the health plan, it is extremely important to disenroll the beneficiary on a timely basis to insure accurate Medicare payments to the HMO. Additionally, HMOs/CMPs need to be aware of disenrollments occurring through FOs so that medical services are not provided by the HMO to the beneficiary after the effective disenrollment date.

After completing the disenrollment form and keying the data into the system, immediately mail the RO and HMO copies of the disenrollment form to the HCFA RO(Attn: HMO Section). See Section K addresses of HCFA ROs. The HCFA RO holds all disenrollment forms received from FOs until the 27th/28th day of the month. On the 27th or 28th day of the month, the RO sends the HMO copies of the disenrollment forms directly to the HMOs from which beneficiaries have disenrolled. This timeframe allows HMOs to be notified on or by the 1st day of the following month of those beneficiaries who have disenrolled from the HMO effective on the 1st day of the month.

In the event that you cannot identify the specific HMO to which a beneficiary belongs, mail the RO and HMO copies to your servicing HCFA RO and keep the FO copy of the form in your office for 90 days. The HCFA RO tries to determine the HMO to which the beneficiary belongs by accessing their Medicare records. In the event the HMO still cannot be identified, the HMO is subsequently notified of the disenrollment by monthly disenrollment reports sent to the HMOs from HCFA central office.

Beneficiaries may also inform the HMO of their disenrollment. This is optional for the beneficiary.

Instruct beneficiaries to return the HMO membership card to the HMO from which they disenroll as soon as possible after the effective disenrollment. Remind beneficiaries not to use the HMO from which they have disenrolled beginning with the effective date of the disenrollment.

In some cases, HMOs affix an identification to the beneficiary Medicare card and, if this is the case, instruct the beneficiary to remove the ID from his/her card on the effective date of disenrollment.

J. Problem HMO Cases

There may be problem HMO cases where beneficiaries were unaware they had enrolled in a plan and want to be disenrolled immediately or retroactively. In these instances, refer the cases to the HMO Section in the HCFA RO for resolution. Only HCFA ROs can process retroactive disenrollments. Adhere to the following procedures:

1. Complete the disenrollment form HCFA-566 and enter items as specified in Section D. This action disenrolls the beneficiary effective the first day of the following month.
2. Inform the beneficiary that his/her disenrollment is effective the first day of the following month and that you are forwarding the case to the HCFA RO for review and possible retroactive disenrollment action.
3. Take a statement (SSA-795) from the beneficiary describing the HMO problem.
4. Include the beneficiary's name, HI number, HMO name, HMO member number (if known), and beneficiary's current address and telephone number where he/she can be reached during the day for possible follow-up contact by the HCFA RO.
5. Immediately mail the beneficiary statement and the RO and HMO copies of the disenrollment form directly to the HMO Section in your servicing HCFA RO. Give the beneficiary his/her copy of the disenrollment form.
6. If the HCFA RO processes the retroactive disenrollment action, it sends the beneficiary a letter after the retroactive disenrollment action has been processed. Any follow-up action needed between HCFA and the beneficiary relative to this case is conducted by the HCFA RO.

K. Addresses of HCFA Regional Offices

Region I

Room 1309
JFK Federal Bldg.
Boston, MA 02203

Region II

Room 3811
26 Federal Plaza
New York, NY 10278

Region III

3535 Market Street
P.O. Box 7760
Philadelphia, PA 19101

Region IV

Suite 701
101 Marietta Tower
Atlanta, GA 30323

Region V

Suite A-835
175 W. Jackson Blvd
Chicago, IL 60604

Region VI

Room 2000
1200 Main Tower Bldg.
Dallas, TX 75202

Region VII

New Federal Office Bldg.
Room 235
601 East 12th Street
Kansas City, MO 64106

Region VII

Federal Bldg.
Room 574
1961 Stout Street
Denver, CO 80294

Region IX

14th Floor
100 Van Ness Ave.
San Francisco CA 94102

Region X

Mail Stop 407
901 Third Ave.
Seattle, WA 98121

L. Automatic Transfers

HCFA has established an automatic transfer process for Medicare beneficiaries who change HMOs. Beneficiaries who enroll in another HMO are automatically disenrolled from the previous HMO in which he/she was a member. If a beneficiary has re-enrolled in a different HMO, the beneficiary does not have to go to the FO or the previous HMO in order to disenroll from the first HMO.

Question beneficiaries regarding possible enrollment in a different HMO before the automatic transfer to a different HMO results in a disenrollment from the new HMO.

M. Exhibit—HCFA-566 (1-88) Revised HMO/CMP Disenrollment Form

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0507

HEALTH MAINTENANCE ORGANIZATION (HMO) / COMPETITIVE MEDICAL PLAN (CMP) DISENROLLMENT FORM

1. BENEFICIARY NAME			
	LAST	FIRST	MI
(BN)			

2. HI CLAIM NUMBER	
	BIC
(CN)	

3. SEX	4. EFFECTIVE DATE			5. TRANSACTION CODE	6. UNIT
	MO	DAY	YR		
(SEX)	(ED)	0 1		(TC) 53	(UN)

M or F

PLEASE COMPLETE THE FOLLOWING

I _____ , request to terminate my membership in _____ . In the
First Name *Last Name* *HMO/CMP NAME*

event that this Health Plan is a "Lock-In" HMO, I understand that I must continue to receive medical services from this HMO

until the effective date of the disenrollment _____ 01 _____ . After the effective date of my disenrollment,
Month *Day* *Year*

I understand that I may receive medical services through the Medicare Fee-For-Service System or any other Prepaid Health

Plan in which I may become a member.

BENEFICIARY SIGNATURE	DATE
BENEFICIARY ADDRESS (STREET, APT., CITY, STATE, ZIP CODE)	BENEFICIARY DAYTIME TELEPHONE NO.

PRIVACY ACT STATEMENT

Section 9312(h) of the Omnibus Reconciliation Act of 1986 authorizes collection of this information. The primary use of this information is to enable Social Security personnel to update your Medicare record in order to disenroll you from your HMO/CMP. Additional disclosures of the information may be to providers and suppliers of services, directly or dealing through Fiscal Intermediaries or Carriers, for administration of Title XVIII.

Furnishing the information on this form is voluntary, but failure to do so may result in disapproval of your disenrollment request.

Social Security Office Copy

00208.075 Role of State Agencies

A. General

Under an agreement between the Secretary, HCFA and each State, a State agency (usually a component of the State Health Department) surveys and recommends to the Secretary whether or not providers and suppliers are eligible to participate in the Medicare program. The State agency's principal activities in this area are:

1. Identifying an institution or facility that might qualify as a provider or supplier for title XVIII and XIX programs, using guidelines provided by the Secretary;
2. Inspecting and certifying (recommending) to the Secretary whether or not the provider or supplier qualifies as a participating provider or supplier;
3. Giving consultation to providers and suppliers to help them sustain their compliance with quality standards to participate in the program;
4. For title XIX purposes, determining whether or not an institution can be paid for treating Medicaid beneficiaries.

For certification purposes, a State agency must establish and maintain methods and criteria for identifying situations in which a question of fraud in obtaining certification may exist. Any such situations are reported to the HCFA Bureau of Quality Control RO having responsibility for investigating Medicare fraud in the area in which the offending facility is located.

State agencies designated to carry out Health Insurance program functions may engage in, and cooperate with, a variety of planning and coordination efforts which have goals similar to those of the Health Insurance Program. These activities include health facility planning, providing for the treatment of mental and chronic diseases, and providing for sufficient community facilities for patient care at appropriate levels of intensity. The Health Insurance Program encourages this coordination and reimburses the State agencies for a fair share of the costs attributable to these activities.

B. Role of State Agencies in Utilization Review

To insure that Medicare beneficiaries receive quality care through sound utilization of institutional facilities and professional services, a utilization review plan based on statutory requirements was included as a condition of participation for hospitals and SNF's. To assure providers are complying with the requirements of utilization review, State agencies periodically review each provider's mechanism. However, where a PSRO is operating, the conditions of participation do not require utilization review.

The Part A intermediary also becomes concerned with such utilization review factors as the proper length of stay and the necessity of the services performed in individual cases. State agencies and intermediaries are encouraged to exchange their findings in utilization review so that they can complement each other's efforts.

00208.080 Role of Professional Standards Review Organizations (PSROs)

The Social Security Act provides for Professional Standards Review Organizations (PSROs) "in order to promote the effective, efficient, and economical delivery of health care services of proper quality."

PSRO's are responsible for reviewing services (and items) for which payment may be made under the Act. The purpose of PSRO review is to determine whether or not: (1) the ser-

HI-B-017

vices are or were medically necessary; (2) the services furnished or proposed to be furnished on an inpatient basis could, consistent with the provision of appropriate medical care, be or have been effectively furnished on an outpatient basis or more economically in an inpatient health care facility of a different type (i.e., determining whether services are or were appropriate; and (3) the quality of the services meets or met professionally recognized standards of health care (i.e., determining whether services are or were of acceptable quality).

Thus, where a PSRO has assumed binding review responsibility, it is responsible for both the initial and reconsideration determinations with respect to the medical necessity, appropriateness, and quality of care of services.

PSROs may also be utilized, where appropriate, by the Secretary for purposes of professional consultation in the exclusion or termination of physicians or other suppliers of health care goods or services. If a PSRO determines that a physician or other supplier of health care goods or services is guilty of abuse against the Medicare or Medicaid programs, it is required to report this to the Health Care Financing Administration (HCFA) for the imposition of whatever sanctions are appropriate. In addition, PSROs are available to advise HCFA or the Medicare contractors as a peer review body with respect to potential overutilization of services, unnecessary services, or services of generally inferior quality.

Where PSROs have implemented binding review authority, the utilization review condition for a facility's participation in the Medicare or Medicaid program is superseded by the PSRO assumption of review. Consequently, the State agency survey of the utilization review activity, discussed in HI 00208.075 B is eliminated. In addition, once a PSRO has binding authority, it is the only entity able to certify services as medically necessary for purposes of Medicare or Medicaid payment. Any initial appeal of a PSRO denial must be directed to the PSRO.

HI00801.022 AHB

00208.085 Role of the Railroad Retirement Board

RRB has responsibility for claims for payment for covered services involving all "qualified railroad retirement beneficiaries" ~~(see CM-10101)~~, except for those services furnished by Group Practice Prepayment Plans (seeHI00208.095) whose membership is not limited to railroad employees or annuitants or their families and for services by plans which deal directly with HCFA.

A. The Responsibilities of RRB

1. ENROLLMENT

RRB enrolls qualified railroad retirement beneficiaries for medical insurance; makes determinations as to the eligibility of such individuals for enrollment; and makes determinations as to the beginning and ending of any coverage period resulting from such enrollment.

2. COLLECTION OF PREMIUMS

RRB collects medical insurance premiums by deduction from annuities (or by remittance when deductions are not possible). However, RRB does not collect premiums from beneficiaries whose premiums are paid by a State.

3. ISSUANCE OF HEALTH INSURANCE CARDS

RRB issues health insurance cards to qualified railroad retirement beneficiaries for whom it has jurisdiction.

B. Contracts Between RRB and Carriers

1. FUNCTIONS TO BE PERFORMED BY CARRIERS

As provided by law, RRB selects and enters into contracts with Part B carrier(s) in the same manner as HCFA. RRB has selected Travelers Insurance as its nationwide representative to process medical insurance claims involving enrollees who are railroad retirement beneficiaries.

NOTE: *The claim of any qualified RR beneficiary is processed by the Travelers Insurance Company even though he is also entitled to RSDI benefits.*

2. COMPARABILITY OF PAYMENTS

RRB is required to take action to assure that payments by its carrier conform to the payments made in the locality for comparable services by the area carrier acting for HCFA. This is intended to keep to a minimum disparities in reasonable charge determinations for services by the same physicians and suppliers. Complaints alleging disparity in payments should be called to the attention of the Medicare Bureau RO.

C. General Provisions of the RRB-HCFA Agreements

1. UTILIZATION RECORDS

Beneficiary utilization records (of deductibles met and payments made under Part B) are maintained by HCFA.

2. EXCHANGE OF INFORMATION

Information is exchanged by HCFA and RRB to the full extent necessary for efficient and effective administration.

3. REIMBURSEMENT

HCFA reimburses the RRB and the carrier for Medicare administrative costs.

4. MODIFICATION AND TERMINATION OF AGREEMENT

The operating agreement between HCFA and RRB may be modified or terminated by either upon reasonable notice which takes into consideration the rights and the needs of beneficiaries. Termination is subject to appropriate notice to the carrier(s) involved.

5. AVAILABILITY OF HCFA SERVICES

RRB may use HCFA facilities and staff when it is more efficient and economical to do so. This is done at the times and under the conditions upon which HCFA and RRB agree.

00208.090 Role of the Part A Intermediaries and Part B Carriers

A. Part A Intermediaries

The Part A intermediary is a national, State, or other public or private agency or organization which has entered into an agreement with HCFA to process Medicare claims received from providers of services. (Providers may choose to deal directly with HCFA rather than an intermediary.)

These agencies or organizations perform such administrative duties as:

1. Determining the reasonable cost for provider services under both Part A and Part B;
2. Making payments directly to providers (in certain instances Part A intermediaries also make payment to beneficiaries);
3. Providing consultative services to assist hospitals, SNF's and HHA's to maintain necessary fiscal records and otherwise qualify as providers;
4. Serving as a center for, and communicating to providers, any information or instruction furnished by HCFA
5. Making audits of provider records;
6. Helping providers with utilization review procedures;
7. Providing the Bureau of Quality Control and the Office of Investigations (OI) with needed information and assistance in the investigation of claims of fraud or abuse against the Medicare program, and, establish controls developed in conjunction with BQC, to minimize the possibility of incorrect Medicare payments;
8. Making payment directly to nonprovider renal dialysis facilities under Part B.

HCFA makes payment for the intermediary's cost of administration and advances funds such as the Government determines to be necessary and proper for carrying out the functions covered by the contract.

The agreement to serve as an intermediary may be terminated by either the intermediary or HCFA under certain conditions specified in the Act and in regulations.

B. Part B Carriers

The Part B carrier is an organization which has entered into an agreement with HCFA to perform specified administrative functions under the medical insurance program. These functions include:

1. Determining the amount of and making payments to beneficiaries and/or physicians, suppliers and others who furnish covered Part B services and supplies;
2. Maintaining benefit payment and related program records which will permit a determination of the quality of the carriers performance;
3. Relaying information pertinent to the administration of the Health Insurance Program;
4. Otherwise assisting in the administration of the medical insurance plan;
5. Providing the Bureau of Quality Control and OI with needed information and assistance in the investigation of claims or fraud or abuse against the Medicare program, and establish controls, developed in conjunction with BQC, to minimize the possibility of incorrect Medicare payments.

Carrier contracts are for a term of at least one year, and are automatically renewed for successive periods of one year in the absence of a 90 day advance notice by the carrier or the Secretary of intention not to renew. A contract provides for payment of the carrier's cost of administration (including the advances of funds) as the Government determines to be necessary and proper for carrying out the functions covered by the contract. HCFA can terminate a contract if it is found that the carrier has failed substantially to carry out its contract or is carrying it out in a manner inconsistent with the efficient administration of the medical insurance program.

00208.095 Group Practice Prepayment Plans

For Medicare purposes, a Group Practice Prepayment Plan (GPPP) is an organization which has a formal arrangement with three or more full time physicians to provide certain health services to the plan's members who have contributed (or have had contributions made on their behalf) toward the costs of services by the advance payment of premiums or dues. These services may be limited to clinic or doctor's office visits or may include the full range of hospital and other provider services.

Under Medicare, hospital costs of individuals who are members of GPPP's are reimbursable in the same manner as other provider services, i.e., the provider bills the Part A intermediary. For Part B nonprovider services, however, special arrangements are necessary inasmuch as charges for physicians' and other health services associated with GPPP's are not made on a fee-for-service basis. Plans may elect to be reimbursed directly by HCFA on a reasonable cost or reasonable charge related to cost basis; these Plans do not file individual bills for Plan services to Plan members. Plans dealing through area carriers file bills for services to Plan members and are reimbursed by the carrier on a reasonable charge related to cost basis. Whether the Plan deals directly with HCFA or through a carrier, services to Plan members furnished outside the Plan are billed in the usual manner through the area carrier.

00208.100 Change of Provider Ownership

When an organization having a provider agreement undergoes a change of ownership, the agreement becomes invalid in relation to the new ownership A participating provider which plans to change ownership gives advance notice of its intention so that necessary action can be taken to enter into an agreement with the newly-owned institution or to give notice to the public in the event the newly-owned institution does not wish to participate in the Medicare program. A participating provider which plans to enter into a lease arrangement (in whole, or in part) should also give advance notice of its intention, because the provider agreement is not transferrable to the lessee.

Refer any contemplated changes of owrership which come to the DO's attention to the HSQRO.

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